DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING _____ B. WING _____	09/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ELIZABETHTON	1641 HIGHWAY 19E ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey and complaint investigation, #32243, conducted from September 16, 2013, through September 18, 2013, at Life Care Center of Elizabethton, no deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	*Life Care Center of Elizabethton is committed to upholding the highest standard of care for our residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health toward the best interest of those that require the services that we provide. While this plan of correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted on September 16-18, 2013. This plan of correction is the facility's allegation of substantial compliance with federal and state requirements.*	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assess bladder incontinence for one resident, #145, of thirty-four residents reviewed. The findings included: Resident # 145 was admitted to the facility on April 9, 2013, and discharged from the facility on June 4, 2013, with diagnoses including Cerebrovascular Accident, Dementia with Behavioral Disturbances, Anemia, Chronic Renal Disease, Hypertension, Diabetes Mellitus, and	F 315	F315 1. <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u> 11/2/13 Resident #145 was discharged prior to Life Care Center of Elizabethton's annual state survey. 2. <u>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u> a. All residents who had a significant change in bladder continence were audited by the director of nursing and the staff development coordinator by October 4, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marladram, LNHA | TITLE: Executive Director | (X6) DATE: 10-4-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 07 2013

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F 315	Continued From page 1 Chronic Obstructive Pulmonary Disease. Medical record review of the admission Minimum Data Set (MDS), dated April 16, 2013, revealed the resident scored an 11/15 on the Brief Interview for Mental Status (BIMS) indicating the resident was moderately cognitively impaired, required extensive assistance with the Activities of Daily Living, and was always continent of urine. Medical record review of the Urinary Incontinence Assessment, with no date, or signature of the nurse performing the assessment, revealed "...is resident incontinent of urine: (no)...Is physical assistance required for toileting? (yes)...does resident require assistive devices that may restrict or facilitate toileting? (urinal, grab bars in bathroom)..." Medical record review of a Nurses Progress Note, dated April 10, 2013, at 12:57 a.m., revealed "...cont (continent) of B&B (bowel and bladder), requires assistance with ADL's (activity of daily living) and transfers..." Medical record review of a significant change MDS, dated May 2, 2013, revealed the resident was frequently incontinent of urine. Medical record review of a Nurses Progress Note, dated May 8, 2013, at 9:03 a.m., revealed "...incontinent of bowel and bladder with pericare PRN (as needed)..." Interview with the Corporate Nurse, on September 17, 2013, at 3:30 p.m., in the Director of Nursing (DON) office, confirmed the resident did have a change in bladder continence, and confirmed the facility did not perform a bladder	F 315	b. No other residents who had a significant change in bladder continence were affected by the alleged deficient practice. 3. <u>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</u> a. The staff development coordinator will educate 100% of licensed nurses by November 2, 2013 on Life Care Center of Elizabethton's Bladder Assessment policy and procedure. b. The director of nursing and the staff development coordinator will review all residents who have been identified as having significant changes in bladder continence to audit for appropriate assessment completion and appropriate intervention for 3 months to the executive director. 4. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.</u> a. The executive director and the director of nursing will present the results of the audits to the Performance Improvement Committee monthly. b. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved. c. The Performance Improvement Committee consists of the executive director, the director of nursing, the medical director, the director of nursing, and the health	11/2/13

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F 315 F 441 SS=D	Continued From page 2 assessment related to the significant change. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 315 F 441	information management director, director of maintenance, director of environmental services, the activities director, the social services director, the admissions director, and the pharmacy consultant. 1. <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u> (CNA) #1 and the activities director were immediately educated on September 16, 2013 regarding Life Care Center of Elizabethton's Infection Control policy related to hand washing during resident dining by the staff development coordinator. 2. <u>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u> a. All residents in the facility being served by a facility associate during resident dining were audited by the director of nursing and the staff development coordinator on September 16, 2013. b. No other residents were affected by this alleged deficient practice. 3. <u>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</u> a. The staff development coordinator will educate 100% of associates by November 2, 2013 on Life Care Center of Elizabethton's Infection Control policy and procedure related to hand washing during resident dining. b. The director of nursing and the staff development coordinator will audit hand washing procedures during resident dining for 3 months and will report findings to the executive director.	11/2/13

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F 441	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility policy, and interview, the facility failed to ensure infection control was maintained in one of three dining rooms. The findings included: Observation on September 16, 2013, at 11:50 a.m., in the resident's main dining room, revealed Certified Nursing Assistant (CNA) #1 and the Activity Director, handing out lunch trays, and touching the resident's trays and the residents without wearing gloves or washing hands. Continued observation revealed this occurred for eighteen of eighteen residents observed. Review of facility policy, Dining, last revised March 1, 2013, revealed "...Associates wash their hands before...serving, and distributing food...Antiseptic hand solution dispensers...available in the dining areas..." Interview with the Director of Nursing (DON), on September 16, 2013, at 11:55 a.m., in the main dining room, confirmed hands must be washed prior to touching a resident's food or food tray and when contact had occurred with the resident. Continued interview with DON confirmed the policy had not been followed.	F 441	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. a. The executive director and the director of nursing will present the results of the audits to the Performance Improvement Committee monthly. b. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits c. director of maintenance, director of environmental services, the reviewed for 3 months or until 100% compliance is achieved. d. The Performance Improvement Committee consists of the executive director, the director of nursing, the medical director, the director of nursing, and the health information management director, activities director, the social services director, the admissions director, and the pharmacy consultant.	11/2/13